FRAMEWORK FOR STATE EVALUATION OF CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

(Developed by States, for States to meet requirements under Section 2108(b) of the Social Security Act)

State/Territory: **NEBRASKA**
(Name of State/Territory)

The following State Evaluation is submitted in compliance with Title XXI of the Social Security Act (Section 2108(b)).

_____
(Signature of Agency Head)

Date: **03/30/2000**

Reporting Period: **May 1, 1998 - September 30, 1999**

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SECTION 1. SUMMARY OF KEY ACCOMPLISHMENTS OF YOUR CHIP PROGRAM

This section is designed to highlight the key accomplishments of your CHIP program to date toward increasing the number of children with creditable health coverage (Section 2108(b)(1)(A)). This section also identifies strategic objectives, performance goals, and performance measures for the CHIP program(s), as well as progress and barriers toward meeting those goals. More detailed analysis of program effectiveness in reducing the number of uninsured low-income children is given in sections that follow.

1.1 What is the estimated baseline number of uncovered low-income children? Is this estimated baseline the same number submitted to HCFA in the 1998 annual report? If not, what estimate did you submit, and why is it different?

The estimated baseline number of uncovered low-income children prior to implementation of the Children's Health Insurance Program (CHIP) in Nebraska was 24,000 children at 185% of the Federal Poverty Level (FPL). This is the baseline reported in HCFA 1998 annual report.

1.1.1 What are the data source(s) and methodology used to make this estimate?

Source: March 1995 Current Population Survey of Nebraska. Census Bureau estimates for 1993-1995. American Hospital Association Health Statistics & the Employee Research Institute (EBRI) analysis of March 1995 Current Population survey of Nebraska.

1.1.2 What is the State's assessment of the reliability of the baseline estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Standard 23.7% error. Documentation of income level and private health insurance for eligibility determination is based on one month at a given point in time. The baseline estimate considers income over time. Families with income which varies by month or over time may be eligible depending on the point in time that application is made. If eligibility criteria are met, eligibility is granted for a 12-month continuous period regardless of changes in income and/or insurance status.

1.2 How much progress has been made in increasing the number of children with creditable health coverage (for example, changes in uninsured rates, Title XXI enrollment levels, estimates of children enrolled in Medicaid as a result of Title XXI outreach, anti-crowd-out efforts)? How many more children have creditable coverage following the implementation of Title XXI? (Section 2108(b)(1)(A))

Through September 1999, 5,983 uninsured children were enrolled in the CHIP program. The total number of uninsured children enrolled in the Medicaid Program in September 1999 was 84,609. Of the 108,102 enrolled children in September 1999, 17,510 had health coverage in addition to *Kids Connection*.

1.2.1 What are the data source(s) and methodology used to make this estimate?

The comparison is not an estimate but is data from our computer eligibility files.

1.2.2 What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

Very reliable. Actual data provided.

1.3 What progress has been made to achieve the State's strategic objectives and performance goals for its CHIP program(s)?

Please complete Table 1.3 to summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in the Title XXI State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List the State's strategic objectives for the CHIP program, as specified in the State Plan.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

For each performance goal specified in Table 1.3, please provide additional narrative discussing how actual performance to date compares against performance goals. Please be as specific as possible concerning your findings to date. If performance goals have not been met, indicate the barriers or constraints. The narrative also should discuss future performance measurement activities, including a projection of when additional data are likely to be available.

SEE excel sheet; clip in here when done.

SECTION 2. BACKGROUND

This section is designed to provide background information on CHIP program(s) funded through Title XXI.

2.1 How are Title XXI funds being used in your State?

2.1.1 List all programs in your State that are funded through Title XXI. (Check all that apply.)

XX Providing expanded eligibility under the State's Medicaid plan (Medicaid CHIP expansion)

Name of program: ***Kids Connection***

Date enrollment began (i.e., when children first became eligible to receive services): **July 1, 1998**

___ Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (State-designed CHIP program)

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Family Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Employer-sponsored Insurance Coverage

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other - Wraparound Benefit Package

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

___ Other (specify) _____

Name of program: _____

Date enrollment began (i.e., when children first became eligible to receive services): _____

2.1.2 **If State offers family coverage:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

2.1.3 **If State has a buy-in program for employer-sponsored insurance:** Please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other CHIP programs.

2.2 What environmental factors in your State affect your CHIP program? (Section 2108(b)(1)(E))

2.2.1 How did pre-existing programs (including Medicaid) affect the design of your CHIP program(s)?

Enacting legislation, Legislative Bill 1063 (1998) allowed the Director of Finance and Support to adopt and promulgate rules and regulations governing provision of medical assistance benefits to qualified individuals as allowed under section 1920A of the federal Social Security Act and as allowed under Title XXI. The legislation also allowed the state to establish eligibility at 185% of the Federal Poverty Level (FPL) as set by the Office of Management and Budget for children under age 19 and to adopt 12-month continuous eligibility for all children under age 19.

Multi-disciplinary workgroups including public, private and advocacy representatives reviewed the options provided to states for development of the state's Children's Health Insurance Program (CHIP). The existing administrative structure for the state's Title XIX (Medicaid) program and the benefit package which could be provided through the existing covered services influenced the state in adopting the CHIP program as a Medicaid expansion. Options for simplifying the eligibility process and providing presumptive eligibility for children were evaluated by the workgroups with recommendations to implement both.

2.2.2 Were any of the preexisting programs "State-only" and if so what has happened to that program?

XX No pre-existing programs were "State-only"

___ One or more pre-existing programs were "State only" ! Describe current status of program(s): Is it still enrolling children? What is its target group? Was it folded into CHIP?

2.2.3 Describe changes and trends in the State since implementation of your Title XXI program that "affect the provision of accessible, affordable, quality health insurance and healthcare for children." (Section 2108(b)(1)(E))

Examples are listed below. Check all that apply and provide descriptive narrative if applicable. Please indicate source of information (e.g., news account, evaluation study) and, where available, provide quantitative measures about the effects on your CHIP program.

XX Changes to the Medicaid program

XX Presumptive eligibility for children
___ Coverage of Supplemental Security Income (SSI) children
No change - Covered pre-CHIP
XX Provision of continuous coverage (specify number of months 12)
___ Elimination of assets tests
No change - No asset test for poverty-related children's programs pre-CHIP
XX Elimination of face-to-face eligibility interviews
XX Easing of documentation requirements

__ Impact of welfare reform on Medicaid enrollment and changes to AFDC/TANF (specify)

XX Changes in the private insurance market that could affect affordability of or accessibility to private health insurance

XX Health insurance premium rate increases
As health insurance rates continue to increase, insurance is becoming less affordable for young families with children.

XX_ Legal or regulatory changes related to insurance
COBRA, HIPAA and the Small Employer Health Insurance Availability Act have had a favorable impact in that more children have access to coverage. Unfortunately, these mandates have also meant an increase in the cost of providing coverage which may have a negative impact on affordability.

XX_ Changes in insurance carrier participation (e.g., new carriers entering market or existing carriers exiting market)
A number of carriers have withdrawn from the State.

___ Changes in employee cost-sharing for insurance

___ Availability of subsidies for adult coverage

XX_ Other (specify) _____
More employers are opting to self-fund benefits.

XX Changes in the delivery system

XX Changes in extent of managed care penetration (e.g., changes in HMO, IPA, PPO activity)

The number of Nebraskans enrolled in HMOs has decreased 14% since December 1996.

XX Changes in hospital marketplace (e.g., closure, conversion, merger)

The passage of the Balanced Budget Act of 1997 had a significant financial stability of hospitals in rural areas. In 1999, three of the state's 64 small rural hospitals closed. Two of these hospitals were located in frontier counties (i.e. less than six persons per square mile)

Although the Balanced Budget Act of 1997 dramatically reduced inpatient and outpatient revenues under the prospective payment system, this Act authorized the Rural Hospital Flexibility Program. This program created a new licensure category called critical access hospitals (CAH). Critical access hospitals were created to help stabilize and sustain the rural health care delivery system.

Currently, a total of 19 rural hospitals in Nebraska are certified as CAHs and another 19 hospitals have submitted applications and are in the process of becoming certified CAHs. By the year 2001, Nebraska is likely to have at least 50 CAHs.

The rapid conversion of hospitals to CAHs should provide financial stability for most rural hospitals and encourage the development of rural health networks that are needed to preserve the rural health system. A strong rural health care system facilitates the recruitment and retention of health care professionals and improves access to high quality health care services for medically under-served populations.

___ Other (specify) _____

___ Development of new health care programs or services for targeted low-income children (specify) _____

___ Changes in the demographic or socioeconomic context

___ Changes in population characteristics, such as racial/ethnic mix or immigrant status (specify)

XX Changes in economic circumstances, such as unemployment rate (specify) _____

Changes in the farm economy affect the affordability of health care for rural families.

XX Other (specify)

Coverage of Pregnant Women in the Title XIX Program at 185% FPL

SECTION 3. PROGRAM DESIGN

This section is designed to provide a description of the elements of your State Plan, including eligibility, benefits, delivery system, cost-sharing, outreach, coordination with other programs, and anti-crowd-out provisions.

3.1 Who is eligible?

3.1.1 Describe the standards used to determine eligibility of targeted low-income children for child health assistance under the plan. For each standard, describe the criteria used to apply the standard. If not applicable, enter "NA."

Table 3.1.1

	Medicaid CHIP Expansion Program	**State-designed CHIP Program**	**Other CHIP Program*** _____ _____ __
Geographic area served by the plan (Section 2108(b)(1)(B)(iv))	**Statewide**		
Age	**Birth - age 18**		
Income (define countable income)	**Countable income* 185% FPL**		
Resources (including any standards relating to spend downs and disposition of resources)	**No resource test**		
Residency requirements	**Must be a Nebraska resident**		
Disability status	**NA**		
Access to or coverage under other health coverage (Section 2108(b)(1)(B)(i))	**CHIP may not have health insurance coverage at time of application**		
Other standards (identify and describe)			

***"Countable Income" = Gross earned income**

- 20% disregard
- cost of child care
+ unearned income
Result must be < 185% FPL

**Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".*

3.1.2 How often is eligibility redetermined?

Table 3.1.2			
Redetermination	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
Monthly			
Every six months			
Every twelve months	**XX**		
Other (specify)			

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.3 Is eligibility guaranteed for a specified period of time regardless of income changes? (Section 2108(b)(1)(B)(v))

XX Yes ° Which program(s)? **Medicaid and CHIP expansion program**

For how long? **12 months** **Unless: 1) Child turns 19 years old**
2) Child moves out of the state
3) Child dies
4) Eligibility granted based on erroneous information
5) Client (parent) request
6) Child enters an ineligible living arrangement (e.g. juvenile detention center)

___ No

3.1.4 Does the CHIP program provide retroactive eligibility?

XX Yes ° Which program(s)? **Medicaid and CHIP expansion program**

How many months look-back? **three months**

___ No

3.1.5 Does the CHIP program have presumptive eligibility?

XX Yes ° Which program(s)? **Medicaid and CHIP expansion program**

Which populations? **Children age birth –18 yr. & Pregnant women**

Who determines? **Approved/trained Presumptive Eligibility Providers**

A qualified entity to determine presumptive eligibility for children is an entity that: 1) is eligible for payments under the Medicaid State Plan and provides items and services covered by the Nebraska Medicaid Assistance Program; or 2) is a qualified provider for presumptive eligibility determinations for pregnant women; or 3) is authorized to determine eligibility of a child – a) to participate in a Head Start program under the Head Start Act; b) to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990; or c) to receive assistance under the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) under section 17 of the Child Nutrition Act of 1966; and 4) is determined to be capable of making presumptive eligibility determinations and has been specifically designated in writing by the Medicaid Division as a qualified entity in accordance with the requirements listed and any other limitations issued by the Health Care Financing Administration (HCFA).

___ No

3.1.6 Do your Medicaid program and CHIP program have a joint application?

XX Yes ° Is the joint application used to determine eligibility for other State programs? If yes, specify. **CHIP and Medicaid Poverty-level children's programs**

___ No

3.1.7 Evaluate the strengths and weaknesses of your *eligibility determination* process in increasing creditable health coverage among targeted low-income children

Strengths: Simplified application form (1-page, 2-sided)

No face-to-face interview necessary

No asset test

Mail-in application form

Statewide toll-free number to call for questions about application/eligibility

Presumptive eligibility for children ensures treatment can begin immediately
Applications available in multiple community accessible locations
Materials available in multiple languages
Health insurance premiums are deducted when determining income eligibility for Title XIX which encourages families to maintain private health insurance policies.

Weaknesses: Centralized eligibility unit can not process applications* when:
The family indicates that they have a private health insurance policy in existence
The family indicates that one of the children received medical services in the previous three months
There is a question of citizenship status
One of the persons that is applying is pregnant or the person completing the application is pregnant
When countable income includes self-employed income
***Determination of eligibility is made at the HHS local office when any of the circumstances listed above exists**

3.1.8 Evaluate the strengths and weaknesses of your *eligibility redetermination* process in increasing creditable health coverage among targeted low-income children. How does the redetermination process differ from the initial eligibility determination process?

Strengths: Short redetermination form (1 page)
Semi-passive – family must only report changes, sign form and return
Must only provide verification if a change is reported
No face-to-face interview required
Can be done through mail
Postage paid envelope included with redetermination form
Approval of eligibility at redetermination begins a new 12-month continuous eligibility period

Weaknesses: Families do not always complete the redetermination form unless or until the child has a medical need
Redetermination form is only available in English

3.2 What benefits do children receive and how is the delivery system structured? (Section 2108(b)(1)(B)(vi))

3.2.1 Benefits

Please complete Table 3.2.1 for each of your CHIP programs, showing which benefits are covered, the extent of cost sharing (if any), and benefit limits (if any).

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

Table 3.2.1 CHIP Program Type_____

Benefit	Is Service Covered? (= yes)	Cost-Sharing (Specify)	Benefit Limits (Specify)
Inpatient hospital services	✓	**NA**	
Emergency hospital services	✓	**NA**	
Outpatient hospital services	✓	**NA**	
Physician services	✓	**NA**	
Clinic services – Rural Health Clinic and Federally Qualified Health Center Services	✓	**NA**	
Prescription drugs	✓	**NA**	
Over-the-counter medications	✓	**NA**	**With prescription from health care provider**
Outpatient laboratory and radiology services	✓	**NA**	
Prenatal care	✓	**NA**	
Family planning services	✓	**NA**	
Inpatient mental health services	✓	**NA**	
Outpatient mental health services	✓	**NA**	
Inpatient substance abuse treatment services	✓	**NA**	
Residential substance abuse treatment services	✓	**NA**	
Outpatient substance abuse treatment services	✓	**NA**	
Durable medical equipment	✓	**NA**	
Disposable medical supplies	✓	**NA**	
Preventive dental services	✓	**NA**	
Restorative dental services	✓	**NA**	
Hearing screening	✓	**NA**	
Hearing aids	✓	**NA**	

Vision screening	✓	**NA**	
Corrective lenses (including eyeglasses)	✓	**NA**	
Developmental assessment	✓	**NA**	
Immunizations	✓	**NA**	
Well-baby visits	✓	**NA**	
Well-child visits	✓	**NA**	
Physical therapy	✓	**NA**	
Speech therapy	✓	**NA**	
Occupational therapy	✓	**NA**	
Physical rehabilitation services	✓	**NA**	
Podiatric services	✓	**NA**	
Chiropractic services	✓	**NA**	**18 treatments during the initial five-month period fron the date of initiation of treatment for the reported diagnosis and a maximum of one treatment per month thereafter if needed for stabilization.**
Medical transportation	✓	**NA**	
Home health services	✓	**NA**	
Nursing facility	✓	**NA**	
ICF/MR	✓	**NA**	
Hospice care			
Private duty nursing	✓	**NA**	
Personal care services	✓	**NA**	
Habilitative services	✓	**NA**	
Case management/Care coordination	✓	**NA**	
Non-emergency transportation	✓	**NA**	
Interpreter services	✓	**Included in calculation for payment as administrative expense**	
Other - Nurse Practitioner and nurse midwife services	✓	**NA**	
Other – ICF/MR services	✓	**NA**	
Other – Audiology services	✓	**NA**	
Other – Screening services	✓	**NA**	

Home and Community based waiver services	✓	**NA**	
Other – Prosthetic and orthopedic devices	✓	**NA**	
Other – Pyschologist services	✓	**NA**	

NOTE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

3.2.2 Scope and Range of Health Benefits (Section 2108(b)(1)(B)(ii))

Please comment on the scope and range of health coverage provided, including the types of benefits provided and cost-sharing requirements. Please highlight the level of preventive services offered and services available to children with special health care needs. Also, describe any enabling services offered to CHIP enrollees. (Enabling services include non-emergency transportation, interpretation, individual needs assessment, home visits, community outreach, translation of written materials, and other services designed to facilitate access to care.)

Nebraska has chosen a Medicaid expansion for its CHIP Program. This has provided a seamless system of care for families, providers and agency staff. The children who are eligible for Nebraska's CHIP program receive the same covered services as the children who are eligible for Medicaid. (See Table 3.2.1 for covered services and limitations.) There is no interruption in eligibility or covered services for children changing eligibility categories between CHIP and Medicaid.

As a Medicaid expansion, there are no cost-sharing requirements for CHIP eligible children.

Certain services require prior authorization (e.g. wheelchairs, orthodontics). There are no restrictions in policy regarding numbers of services except in chiropractic services. By State Statute manual manipulation of the spine is limited to 18 treatments during the initial five-month period from the date of initiation of treatment for the reported diagnosis and a maximum of one treatment per month is covered thereafter if needed for stabilization care.

The Early Periodic Screening Diagnosis and Treatment (EPSDT) Program, referred to in Nebraska as HEALTHCHECK, provides screening and preventive health services for children birth through age 18 (age 20 for Medicaid eligible children). These services include risk reduction services and nutritional counseling, childbirth preparation, infant care, and home visitation services. Certain mental health and substance abuse treatment services are covered as HEALTHCHECK follow-up treatment services so that care is

provided in the least restrictive, family-centered, community-based, culturally competent, and developmentally appropriate manner. Dental sealants are also covered for children.

Medical transportation and related travel expenses are provided as enabling services to assist families in accessing care. Ambulatory room and board services are covered when necessary through a network of hospital providers. HMO managed care plans and fee-for-service providers are also required to provide translation services.

Community outreach and individual needs assessment is provided through a network of public health nurses located at county health departments and community action agencies through Medicaid administrative contracts. Public Health Outreach and Nursing Education (PHONE) covers nearly every county in the state not included in Medicaid managed care. Medicaid managed care is mandatory in only three counties: Douglas, Sarpy and Lancaster. The PHONE network provides: single phone access to nurses who assess individual needs and barriers to care; secure medical and dental homes for Medicaid and CHIP enrolled children and families; information and referral to additional community health services; Medicaid, CHIP and EPSDT outreach and case management; and education to families regarding appropriate access to primary care and emergency services.

3.2.3 Delivery System

Identify in Table 3.2.3 the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Check all that apply.

Table 3.2.3			
Type of delivery system	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
A. Comprehensive risk managed care organizations (MCOs)			
Statewide?	___ Yes **XX** No	___ Yes ___ No	___ Yes ___ No
Mandatory enrollment?	****** Yes ___ No	___ Yes ___ No	___ Yes ___ No
Number of MCOs	**2**		
B. Primary care case management (PCCM) program	***** Yes, not statewide**		
C. Non-comprehensive risk contractors for selected services such as mental health, dental, or vision (specify services that are carved out to managed care, if applicable)	**Behavioral health carve out through a statewide pre-paid health plan**		
D. Indemnity/fee-for-service (specify services that are carved out to FFS, if applicable)	**Dental, Pharmacy, Nursing home, Personal Care Aides**		
E. Other (specify)			
F. Other (specify)			
G. Other (specify)			

****Managed care mandatory clients may choose HMO or Primary Care Case Management (PCCM) plan.**

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a

table, right click on the mouse, select “insert” and choose “column”.

3.3 How much does CHIP cost families?

3.3.1 Is cost sharing imposed on any of the families covered under the plan? (Cost sharing includes premiums, enrollment fees, deductibles, coinsurance/ copayments, or other out-of-pocket expenses paid by the family.)

XX No, skip to section 3.4

___ Yes, check all that apply in Table 3.3.1

Table 3.3.1

Type of cost-sharing	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program*_____ _____ _
Premiums			
Enrollment fee			
Deductibles			
Coinsurance/copayments**			
Other (specify) _____			

*Make a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

**See Table 3.2.1 for detailed information.

3.3.2 **If premiums are charged:** What is the level of premiums and how do they vary by program, income, family size, or other criteria? (Describe criteria and attach schedule.) How often are premiums collected? What do you do if families fail to pay the premium? Is there a waiting period (lock-out) before a family can re-enroll? Do you have any innovative approaches to premium collection?

3.3.3 **If premiums are charged:** Who may pay for the premium? Check all that apply. (Section 2108(b)(1)(B)(iii))

___ Employer

___ Family
___ Absent parent
___ Private donations/sponsorship
___ Other (specify) _____

3.3.4 **If enrollment fee is charged:** What is the amount of the enrollment fee and how does it vary by program, income, family size, or other criteria?

3.3.5 **If deductibles are charged:** What is the amount of deductibles (specify, including variations by program, health plan, type of service, and other criteria)?

3.3.6 How are families notified of their cost-sharing requirements under CHIP, including the 5 percent cap?

3.3.7 How is your CHIP program monitoring that annual aggregate cost-sharing does not exceed 5 percent of family income? Check all that apply below and include a narrative providing further details on the approach.

___ Shoebox method (families save records documenting cumulative level of cost sharing)
___ Health plan administration (health plans track cumulative level of cost sharing)
___ Audit and reconciliation (State performs audit of utilization and cost sharing)
___ Other (specify)_____

3.3.8 What percent of families hit the 5 percent cap since your CHIP program was implemented? (If more than one CHIP program with cost sharing, specify for each program.)

3.3.9 Has your State undertaken any assessment of the effects of premiums on participation or the effects of cost sharing on utilization, and if so, what have you found?

3.4 How do you reach and inform potential enrollees?

3.4.1 What client education and outreach approaches does your CHIP program use?

Please complete Table 3.4.1. Identify all of the client education and outreach approaches used by your CHIP program(s). Specify which approaches are used (**T**=yes) and then rate the effectiveness of each approach on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.1

Approach	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Billboards						
Brochures/flyers	✓	**5**				
Direct mail by State/enrollment broker/*administrative contractor*	✓	**4**				
Education sessions	✓	**3**				
Home visits by State/enrollment broker/***administrative contractor***	✓	**5**				
Hotline	✓	**5**				
Incentives for education/outreach staff						
Incentives for enrollees						
Incentives for insurance agents						

Non-traditional hours for application intake						
Prime-time TV advertisements						
Public access cable TV						
Public transportation ads						
Radio/newspaper/TV advertisement and PSAs	✓	**3**				
Signs/posters	✓	**4**				
State/broker initiated phone calls						
Other (specify)						
Application forms provided through public schools	✓	**5**				
Application forms provided through parochial schools	✓	**5**				
Toll free telephone number printed on free and reduced lunches letter to parents	✓	**2**				
Tray-liners at McDonald's restaurant	✓	**1**				
Grocery sacks	✓	**1**				
Tear off tablets	✓	**3**				
Grocery store "shelf-talkers"	✓	**2**				
Envelope stuffer	✓	**3**				
Direct mail of brochure to rural postal box holders	✓	**5**				
Health fairs, Neighborhood carnivals, School carnivals/fun nights, and other similar neighborhood and school activities	✓	**3**				

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Booth at State Fair and County Fairs	✓	**2**				
Direct mail of video to Medicaid enrolled primary care providers – referrals from health care providers	✓	**5**				
Video for families, community agencies and other interested groups	✓	**3**				
Direct mail of applications to Medicaid enrolled providers	✓	**5**				

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.4.2 Where does your CHIP program conduct client education and outreach?

Please complete Table 3.4.2. Identify all the settings used by your CHIP program(s) for client education and outreach. Specify which settings are used (**T**=yes) and then rate the effectiveness of each setting on a scale of 1 to 5, where 1=least effective and 5=most effective.

Table 3.4.2

Setting	Medicaid CHIP Expansion		State-Designed CHIP Program		Other CHIP Program* _____	
	T = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)	**T** = Yes	Rating (1-5)
Battered women shelters						
Community sponsored events	✓	**3**				
Beneficiary's home	✓	**5**				
Day care centers	✓	**2**				
Faith communities	✓	**1**				
Fast food restaurants	✓	**1**				
Grocery stores	✓	**2**				
Homeless shelters						
Job training centers						
Laundromats						

Libraries						
Local/community health centers	✓	**3**				
Point of service/provider locations	✓	**5**				
Public meetings/health fairs	✓	**2**				
Public housing	✓	**2**				
Refugee resettlement programs						
Schools/adult education sites	✓	**5**				
Senior centers						
Social service agency	✓	**5**				
Workplace						
Other (specify)						
Other (specify)						

*Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.4.3 Describe methods and indicators used to assess outreach effectiveness, such as the number of children enrolled relative to the particular target population. Please be as specific and detailed as possible. Attach reports or other documentation where available.

treach efforts are tracked through the statewide toll-free telephone number by surveying clients as to where they heard about the program. Applications have also been "marked" when distributed at specific events such as the State Fair to track the number completed and returned to the central processing unit. In addition, community outreach workers (PHONE public health network and *Covering Kids* grantee pilot sites) track applications completed to determine success in identifying target population (# of applications approved for eligibility/# of applications distributed). Effectiveness is also measured in terms of "who has heard about the program" at community events and success of outreach staff in talking about the program with others that may have contact with eligible families, such as teachers, day care providers, etc.

3.4.4 What communication approaches are being used to reach families of varying ethnic backgrounds?

terials are printed in multiple languages. Posters are available in English and Spanish (Vietnamese to be available soon). Applications are available in English, Spanish, Vietnamese, Russian and Arabic. Outreach has been conducted using various media approaches including television PSAs, radio PSAs, written materials provided through school student packets, verbal communication through one-on-one contact and community presentations.

3.4.5 Have any of the outreach activities been more successful in reaching certain populations? Which methods best reached which populations? How have you measured their effectiveness? Please present quantitative findings where available.

ool outreach efforts have been the most successful in increasing the number of applications received. Each fall applications are provided to each public school district for inclusion in the student packets for every student kindergarten through 12th grade.

rough the statewide network of public health nurses (PHONE) and the *Covering Kids* grantee, outreach efforts at the community level have proven to be very successful by providing families with one-on-one application assistance and a source of information which is credible and familiar to them.

What other health programs are available to CHIP eligibles and how do you coordinate with them? (Section 8(b)(1)(D))

Describe procedures to coordinate among CHIP programs, other health care programs, and non-health care programs. Table 3.5 identifies possible areas of coordination between CHIP and other programs (such as Medicaid, MCH, WIC, School Lunch). Check all areas in which coordination takes place and specify the nature of coordination in narrative text, either on the table or in an attachment.

able 3.5

pe of coordination	Medicaid*	Maternal and child health	Other (specify) WIC	Other (specify) Immunization Clinics	Other (specify) School Lunch Program	Other (specify) Food Stamps
ministration						✓
treach		✓	✓	✓	✓	✓
gibility determination		✓ **Presumptive eligibility only**				✓
vice delivery						✓
ocurement						
ntracting						
ta collection						✓
ality assurance						
ner (specify)						
ner (specify)						

ote: This column is not applicable for States with a Medicaid CHIP expansion program only.

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How do you avoid crowd-out of private insurance?

3.6.1 Describe anti-crowd-out policies implemented by your CHIP program. If there are differences across programs, please describe for each program separately. Check all that apply and describe.

___ Eligibility determination process:

___ Waiting period without health insurance (specify)

XX Information on current or previous health insurance gathered on application (specify) **Current**

___ Information verified with employer (specify)

XX Records match (specify)

electronic records match of all *Kids Connection* enrollees is done on a monthly basis with the largest health insurer in the state. If a match on 3 of 4 criteria is found, the policy is auto-loaded onto the client's eligibility file. The Department is pursuing procedures to follow-up this process to determine if the policy was in effect on the date of application.

___ Other (specify)

___ Other (specify)

___ Benefit package design:

___ Benefit limits (specify)

___ Cost-sharing (specify)

___ Other (specify)

___ Other (specify)

___ Other policies intended to avoid crowd out (e.g., insurance reform):

___ Other (specify)

___ Other (specify) _____

3.6.2 How do you monitor crowd-out? What have you found? Please attach any available reports or other documentation.

te Statute established the *Kids Connection* Study Committee. The committee is mandated to

determine crowd-out and report (by September 1, 2000) to the State Legislature.

CTION 4. PROGRAM ASSESSMENT

s section is designed to assess the effectiveness of your CHIP program(s), including enrollment, disenrollment, enditures, access to care, and quality of care.

Who enrolled in your CHIP program?

4.1.1 What are the characteristics of children enrolled in your CHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your CHIP programs, based on data from your HCFA quarterly enrollment reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

TE: To duplicate a table: put cursor on desired table go to Edit menu and chose "select" "table." Once the table is highlighted, copy it by selecting "copy" in the Edit menu and then "paste" it under the first table.

able 4.1.1 CHIP Program Type **_Medicaid Expansion_____**

aracteristics	Number of children ever enrolled		Average number of months of enrollment		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Children	**2,119**	**9,713**	**1.1**	**5.7**		**493***
e						

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der 1	**39**	**284**	**1.4**	**3.5**		**12**
	325	**1,957**	**1.1**	**4.5**		**83**
2	**1,017**	**4,143**	**1.1**	**6.2**		**228**
18	**738**	**3,329**	**1.1**	**6.0**		**170**
untable Income vel*						
or below 150% L	**0**	**0**	**-**	**-**		**-**
ove 150% FPL	**2,119**	**9,713**	**1.1**	**5.7**		**493**
e and Income						
der 1						
At or below 150% FPL	**0**	**0**	**-**	**-**		**0**
Above 150% FPL	**39**	**284**	**1.4**	**3.5**		**12**
At or below 150% FPL	**0**	**0**	**-**	**-**		**0**
Above 150% FPL	**325**	**1,957**	**1.1**	**4.5**		**83**
2						
At or below 150% FPL	**0**	**0**	**-**	**-**		**0**
Above 150% FPL	**1,017**	**4,143**	**1.1**	**6.2**		**228**

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18						
At or below 150% FPL	**0**	**0**	**-**	**-**		**0**
Above 150% FPL	**738**	**3,329**	**1.1**	**6.0**		**170**
pe of plan						
e-for-service	**1,929**	**2,384**	**1.1**	**3.4**		
naged care	**188**	**7,228**	**1.1**	**6.5**		
CM	**2**	**101**	**1.0**	**5.0**		

his number is calculated by the state and represents CHIP enrolled children who are no longer eligible ing FFY99 for CHIP or Medicaid. The number does not include children who, through the screen and oll process, were determined eligible in a Medicaid (Title XIX) category.

ountable Income Level is as defined by the states for those that impose premiums at defined levels other than % FPL. See the HCFA Quarterly Report instructions for further details.

RCE: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998

4.1.2 How many CHIP enrollees had access to or coverage by health insurance prior to enrollment in CHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

CHIP enrollees had health insurance coverage at the time of application/eligibility determination. The source for this data is the application.

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

e existing Medicaid program was effective in increasing the availability of health coverage for children.

Who disenrolled from your CHIP program and why?

4.2.1 How many children disenrolled from your CHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do CHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

ere were 493 children disenrolled from the CHIP program during federal fiscal year 1999. Nebraska has no previous experience with 12-month continuous eligibility. The disenrollment rate is smaller than before implementation of 12-month continuous eligibility for children. See the disenrollment table below for reasons for disenrollment.

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left CHIP?

e state has not at this time evaluated re-enrollment at the end of the 12-month continuous eligibility period. Antecdotally, caseworkers are reporting that some families are not responding to the re-determination request until they receive a notice of closure of the case.

4.2.3 What were the reasons for discontinuation of coverage under CHIP? (Please specify data source, methodologies, and reporting period.)

able 4.2.3

ason for continuation of verage	Medicaid CHIP Expansion Program		State-designed CHIP Program		Other CHIP Program* _____	
	Number of disenrollees	Percent of total*	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
tal	**493**					
cess to nmercial urance	**10**	**2%**				
gible for dicaid	**Children who move to a Title XIX category were not counted as disenrolled**					
ome too high	**20**	**4%**				
ed out of gram	**5**	**<1%**				
ved/died	**74**	**15%**				
npayment of mium	**NA**					
omplete cumentation	**79**	**16%**				
d not ly/unable to ntact	**173**	**35%**				
er: **Client quest**	**54**	**11%**				

her: **Child left ne, situation known**	**36**	**7%**				
her: **Court minated**	**25**	**5%**				
her: Each <1% **ild relinquished juvenile ention facility tus Unknown longer disabled S – goals ieved S – guardian ablished S – unable to ate**	**17**	**<1%**				
her:						
n't know:						

hese percentages are based on review of reasons for disenrollments for all children (Medicaid and IP) and allocated to the reasons for disenrollment based on the number of CHIP disenrollees.

ake a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right k on the mouse, select "insert" and choose "column".

4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

e of access: mail-in shortened application form, mailing and school distribution of applications/information. Disenrollment is not automatic. Families receive a notice before disenrollment is activated.

How much did you spend on your CHIP program?

4.3.1 What were the total expenditures for your CHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998 _____$**431***_____

FFY 1999 _ $**4,212,654***_____

*** Program costs only. Does not include administrative costs.**

Please complete Table 4.3.1 for each of your CHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

able 4.3.1 CHIP Program Type Medicaid Expansion

pe of expenditure	Total computable share		Total federal share	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999
tal expenditures	**431**	**4,212,654**	**314**	**3,076,080**
emiums for private alth insurance (net cost-sharing sets)*				
e-for-service penditures (subtotal)	**431**	**4,212,654**	**314**	**3,076,080**
atient hospital vices	**0**	**602,052**	**0**	**439,618**
atient mental health ility services	**0**	**45,840**	**0**	**33,472**
rsing care services	**0**	**0**	**0**	**0**

ysician and surgical vices	**0**	**621,690**	**0**	**453,958**
tpatient hospital vices	**0**	**424,599**	**0**	**310,042**
tpatient mental lth facility services	**Included in outpatient services***			
scribed drugs	**367**	**608,609**	**267**	**444,406**
ntal services	**64**	**650,995**	**47**	**475,357**
sion services	**Included in physician services***			
ner practitioners' vices	**0**	**211,850**	**0**	**154,693**
nic services	**0**	**47,061**	**0**	**34,364**
erapy and abilitation services	**Included in outpatient, clinic and other practitioner services***			
oratory and iological services	**0**	**58,160**	**0**	**42,468**
rable and posable medical ipment	**Included in other services***			
nily planning	**0**	**12,066**	**0**	**8,881**
ortions	**0**	**0**	**0**	**0**
eening services	**0**	**80,630**	**0**	**58,876**
me health	**0**	**8,857**	**0**	**6,467**
me and community-sed services**	**0**	**0**	**0**	**0**
spice	**0**	**0**	**0**	**0**
dical nsportation***	**0**	**0**	**0**	**0**
se management***	**0**	**0**	**0**	**0**
ner services	**0**	**164,272**	**0**	**119,951**

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naged care itation payments		**675,973**		**493,595**

ot separately reported

There were no expenditures for CHIP children receiving home and community based services as dren eligible for those services would be categorized in a Medicaid eligibility category.

Included as administrative expense in payment to provider.

2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

What types of activities were funded under the 10 percent cap?

Outreach and Administration such as:

rketing **Printing** **Quality assurance activities**
treach **Data collection** **Eligibility determination**
essment of the State plan **Coordination w/other public/private entities**
ff salaries **Program Planning**

What role did the 10 percent cap have in program design?

braska elected a Medicaid expansion for the CHIP program in part because total administrative costs for Medicaid as a percentage of expenditures are less than 10%.

able 4.3.2

pe of expenditure	Medicaid Chip Expansion Program		State-designed CHIP Program		Other CHIP Program* _____	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
tal computable share	**Nebraska's cost allocation plan has been amended to allow claiming CHIP expenditures**					
treach						
ministration						
ner_____						
deral share	**Nebraska's cost allocation plan has been amended to allow claiming CHIP expenditures**					

treach						
ministration						
ner _______						

ake a separate column for each “other” program identified in section 2.1.1. To add a column to a table, right k on the mouse, select “insert” and choose “column”.

4.3.3 What were the non-Federal sources of funds spent on your CHIP program (Section 2108(b)(1)(B)(vii))

XX State appropriations
___ County/local funds
___ Employer contributions
XX Foundation grants-- **Robert Woods Johnson *Covering Kids* Grant for outreach activities**
___ Private donations (such as United Way, sponsorship)
XX Other (specify) **In-kind contribution from EPSDT administrative contractors, health care associations and others to outreach to eligible families**
XX Other (specify) Cash **funds from Nebraska Health Insurance Trust Fund.**

How are you assuring CHIP enrollees have access to care?

4.4.1 What processes are being used to monitor and evaluate access to care received by CHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in a Primary Care Case Management program, specify 'PCCM.'

ble 4.4.1

proaches to monitoring access	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
pointment audits	**through managed care plans**		
P/enrollee ratios	**through managed care plans**		

ne/distance standards	**through managed care plans**		
gent/routine care access standards	**through managed care plans**		
twork capacity reviews (rural viders, safety net providers, cialty mix)	**through managed care plans**		
mplaint/grievance/ enrollment reviews	**through managed care plans**		
se file reviews	**through managed care plans**		
neficiary surveys	**through managed care plans & enrollment broker**		
lization analysis (emergency room , preventive care use)	**through managed care plans and statewide public health nurse administrative contracts**		
ner (specify) _____			
ner (specify) _____			
ner (specify) _____			

ake a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right k on the mouse, select "insert" and choose "column".

4.4.2 What kind of managed care utilization data are you collecting for each of your CHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

able 4.4.2

pe of utilization data	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program* _____
quiring submission of raw counter data by health plans	✓ Yes ___ No	___ Yes ___ No	___ Yes ___ No
quiring submission of aggregate DIS data by health plans	✓ Yes ____No	___ Yes ___ No	___ Yes ___ No
her (specify)**Quarterly Reports m MCOs, PCCM, PHP**	✓ Yes ___ No	___ Yes ___ No	___ Yes ___ No

ake a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right k on the mouse, select "insert" and choose "column".

4.4.3 What information (if any) is currently available on access to care by CHIP enrollees in your State? Please summarize the results.

Health Plans perform satisfaction surveys. The two HMOs use the nationally standardized Consumer Assessment of Health Plans Survey (CAHPS) and report this information to the National Committee on Quality Assurance (NCQA) as required. Share Advantage provided a copy of the survey results to the Department. Wellness Option has completed the survey and provided a brief summary of results. The Department conducts consumer satisfaction surveys for the Primary Care Case Management (PCCM) model. The survey was completed in September 1999. The results are expected to be reported by June 30, 2000. The PCCM parent company (an HMO) performs the CAHPS survey as well and provides a summary of the results of that survey to the Department. The mental health substance abuse vendor will complete an annual satisfaction survey upon approval by NCQA. The mental health substance abuse vendor is actively seeking accreditation status as a Behavioral Health Organization. The mental health substance abuse health plan performs a small sample of satisfaction surveys on an ongoing basis. In addition, the Managed Care Enrollment Broker conducts phone and mail surveys with the newly enrolled population to determine satisfaction with the enrollment process, the health status assessment and staff advocacy on matters related to access and quality of care.

4.4.4 What plans does your CHIP program have for future monitoring/evaluation of access to care by CHIP enrollees? When will data be available?

e initial Quality Improvement Committee will review data for assessment of program performance. The Department will also maximize NCQA accreditation guides for overall application. Data will be available for the next CHIP reporting period.

How are you measuring the quality of care received by CHIP enrollees?

4.5.1 What processes are you using to monitor and evaluate quality of care received by CHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO.' If an approach is used in fee-for-service, specify 'FFS.' If an approach is used in primary care case management, specify 'PCCM.'

able 4.5.1

proaches to monitoring ality	Medicaid CHIP Expansion Program	State-designed CHIP Program	Other CHIP Program
cused studies (specify)	**MCO, PCCM, EB*, PHP****		
ent satisfaction surveys	**PCCM, PHP**		
mplaint/grievance/ enrollment reviews	**MCO, PCCM, EB, FFS, PHP**		
ntinel event reviews	**MCO, PCCM, EB, FFS, PHP**		
n site visits	**MCO, PCCM, EB, PHP**		
se file reviews	**MCO, PCCM, EB, PHP**		
ependent peer review	**MCO, PCCM, PHP**		
DIS performance asurement	**MCO,PCCM, FFS, PHP**		
ner performance asurement (specify) **ategic Objectives in Title I State Plan**	**MCO, PCCM, FFS, PHP**		
ner (specify) _____			

her (specify) _____			
her (specify) _____			

ake a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right k on the mouse, select "insert" and choose "column".

3 = Enrollment Broker

PHP = Prepaid Health Plan for Mental Health Substance Abuse Services

4.5.2 What information (if any) is currently available on quality of care received by CHIP enrollees in your State? Please summarize the results.

EPSDT related quality focus study was performed for fiscal year 1998 (July 1, 1997-June 30, 1998). The Department's objective was to determine the extent to which Nebraska Medicaid Managed Care Program children were receiving health screens and if they were receiving all components of the screen. Each primary health care plan was asked to provide a sample of medical records. From these records data was extracted by RN reviewers using a tool developed for this purpose. Four rates were calculated: EPSDT participation rate; 6 and 12 month rates, a rate of compliance with the screening components and the complete visit rate. Findings included: 1) a fairly high proportion of children received at least one EPSDT visit, few received a complete assessment at each visit and very few received well child care at recommended intervals; 2) two and four-month olds had the highest proportion of children who received the "core components" of an EPSDT visit; 3) because the Department wanted to obtain a broad picture of EPSDT rates, all ages of children were reviewed and consequently a statiscally representative sample of each plan was not obtained (407 records reviewed); 4) although the numbers are small, this study provided the Department with the most detailed information about EPSDT rates and other relevant information, such as the completeness of the medical record; 5) EPSDT participation rate for children 6 and under was 69%; 6) EPSDT participation rate for children 7 and older was 50%; 7) 35% of the children had an office visit, but no evidence of EPSDT services (physical exams were used as proxies for EPSDT visits; 8) 6 and 12 month visit rates revealed that only 12% of children received 3 or more visits in the first 6 months; 9) 6 and 12 month visit rates revealed that only 8% of children received 5 or more visits in the first 12 months; 10) 67% of children were recorded as not receiving a visit between 1 and 3 months; and 11) rate of compliance with all components indicated that hearing , vision, and laboratory testing were

under reported for young infants, for older children laboratory testing and immunizations were under reported.

4.5.3 What plans does your CHIP program have for future monitoring/evaluation of quality of care received by CHIP enrollees? When will data be available?

Table 1.3 Performance objective 5. All of the information is to be available by the measurement time specified.

Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program's performance. Please list attachments here.

CTION 5. REFLECTIONS

s section is designed to identify lessons learned by the State during the early implementation of its CHIP program vell as to discuss ways in which the State plans to improve its CHIP program in the future. The State evaluation uld conclude with recommendations of how the Title XXI program could be improved.

What worked and what didn't work when designing and implementing your CHIP program? What lessons have you learned? What are your "best practices"? Where possible, describe what evaluation efforts have been completed, are underway, or planned to analyze what worked and what didn't work. Be as specific and detailed as possible. (Answer all that apply. Enter 'NA' for not applicable.)

5.1.1 Eligibility Determination/Redetermination and Enrollment

e simplification of the application process has been a success of the program. Development of a 1-page (2-sided) application form and elimination of the face-to-face interview have eliminated some of the barriers to enrollment for eligible families. Implementation of presumptive eligibility for children has been a benefit for clients and providers by providing an opportunity for continuity of care and implementation of treatment upon evaluation by the provider. Twelve-month continuous eligibility has also promoted continuity of care and has been a provider-friendly strategy. The re-determination process has been simplified to encourage families to maintain enrollment.

5.1.2 Outreach

treach through schools has been the most successful strategy for increasing enrollment. The multi-media, multi-faceted outreach strategies employed by the state have allowed Nebraska to reach a variety of populations and audiences. Partnerships with health care associations (Dental Association, Pharmacy Association, Medical Society, Hospital Association, and others) and other entities (Retail Grocer's Association, AmeriCore, and others) have enabled us to use limited resources for statewide outreach. Partnership and collaboration with the public health nurse network (PHONE) and *Covering Kids* grantee have enabled us to conduct outreach at the community level and provide families with additional benefits such as securing a medical or dental home and obtaining assistance to complete the application form.

5.1.3 Benefit Structure

IP enrolled children receive all Medicaid covered services which provides children access to preventive services, mental health and substance abuse services, as well as treatment for medical conditions. Dental and visual care promotes the child's health for optimal learning in school.

5.1.4 Cost-Sharing (such as premiums, copayments, compliance with 5% cap)

Applicable

5.1.5 Delivery System

e of the advantages of a CHIP Medicaid expansion is a delivery system with which health care providers are familiar. Educating providers that the CHIP program is a Medicaid expansion allowed them to adapt the processes they were familiar with in providing services to Medicaid eligible children to CHIP enrolled children. Examples of these processes include verifying eligibility, payment and billing procedures, criteria for covered services. Confusion and questions from providers were avoided as implementation efforts focused on the expansion of Medicaid rather than a new and/or different program administered by the state. Health care providers were also educated as to the benefits to them in providing medical coverage to children through CHIP in a video introducing the program.

ial marketing and outreach efforts attempted to overcome barriers to families enrolling such as the long-standing connection of Medicaid and welfare while maintaining the relationship of the CHIP expansion program to the existing Medicaid program as the programs share the same provider network and benefit package. The goal of both programs and all marketing and outreach efforts has

been to provide access to care for families regardless of the category of eligibility.

5.1.6 Coordination with Other Programs (especially private insurance and crowd-out)

braska has used a broad approach to coordination with other programs by partnerships with others such as the Title V Maternal and Child Health Program, Immunization Program, Medically Handicapped Children's Program, Early Intervention Program and Special Education Services, WIC, and others. This coordination allows for referals between the programs with the family's needs as the focus.

5.1.7 Evaluation and Monitoring (including data reporting)

braska is just beginning the evaluation process. The success and effectiveness of outreach strategies is variable and hard to measure however, efforts are being made as new strategies are implemented to determine an evaluation process prior to implementation. The program will continue to be monitored for success in reducing the number of uninsured low-income children in the state, disenrollment of children, re-enrollment, service utilization and quality of care.

5.1.8 Other (specify)

What plans does your State have for "improving the availability of health insurance and health care for children"? (Section 2108(b)(1)(F))

What recommendations does your State have for improving the Title XXI program? (Section 2108(b)(1)(G))

minate redundant reporting.

ow CHIP FFP for children screened and enrolled into the Medicaid program as a result of CHIP outreach and simplification of the application process.

Addendum to Table 3.1.1

following questions and tables are designed to assist states in reporting countable income levels for their dicaid and SCHIP programs and included in the NASHP SCHIP Evaluation Framework (Table 3.1.1). This nical assistance document is intended to help states present this extremely complex information in a structured nat.

questions below ask for countable income levels for your Title XXI programs (Medicaid SCHIP expansion and e-designed SCHIP program), as well as for the Title XIX child poverty-related groups. Please report your ibility criteria as of **September 30, 1999.** Also, if the rules are the same for each program, we ask that you enter dicate information in each column to facilitate analysis across states and across programs.

ou have not completed the Medicaid (Title XIX) portion for the following information and have passed it along to dicaid, please check here **9** and indicate who you passed it along to. Name_____, ne/email_____

1.1 For each program, do you use a gross income test or a net income test or both?

e XIX Child Poverty-related Groups	____Gross	__**X**_Net	____Both
e XXI Medicaid SCHIP Expansion	____Gross	__**X**_Net	____Both
e XXI State-Designed SCHIP Program	____Gross	____Net	____Both
er SCHIP program_____	____Gross	____Net	____Both

1.2 What was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately.

Title XIX Child Poverty-related Groups	_**150**% of FPL for children under age _**1**____
	_**133**% of FPL for children aged _**1 - 5**_____
	_**100**% of FPL for children aged _**6 – 18**___
Title XXI Medicaid SCHIP Expansion	_**185**% of FPL for children aged _**0 – 18**___

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____% of FPL for children aged _____

	____% of FPL for children aged _____
Title XXI State-Designed SCHIP Program	____% of FPL for children aged _____
	____% of FPL for children aged _____
	____% of FPL for children aged _____
Other SCHIP program_____	____% of FPL for children aged _____
	____% of FPL for children aged _____
	____% of FPL for children aged _____

3.1.1.3 Complete Table 1.1.1.3 to show whose income you count when determining eligibility for each program and which household members are counted when determining eligibility? (In households with multiple family units, refer to unit with applicant child)

Enter "Y" for yes, "N" for no, or "D" if it depends on the individual circumstances of the case.

Table 3.1.1.3

Family Composition	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Child, siblings, and legally responsible adults living in the household	D	D		

All relatives living in the household	D	D		
All individuals living in the household	D	D		
Other (specify)				

3.1.1.4 How do you define countable income? For each type of income please indicate whether it is counted, not counted or not recorded. ***Enter "C" for counted, "NC" for not counted and "NR" for not recorded.***

Table 3.1.1.4				
Type of Income	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings Earnings of dependent children	C NC	C NC		
Earnings of students	NC	NC		
Earnings from job placement programs	C*	C*		

Earnings from community service programs under Title I of the National and Community Service Act of 1990 (e.g., Serve America)	C	C		
Earnings from volunteer programs under the Domestic Volunteer Service Act of 1973 (e.g., AmeriCorps, Vista)	C*	C*		
Education Related Income Income from college work-study programs	NC	NC		
Assistance from programs administered by the Department of Education	C	C		
Education loans and awards	NC	NC		
Other Income Earned income tax credit (EITC)	NC	NC		
Alimony payments received	C	C		
Child support payments received	C	C		
Roomer/boarder income	C	C		
Income from individual development accounts	NR	NR		
Gifts	NC	NC		
In-kind income **Shelter Only**	C	C		

C* - Depends on individual circumstances of the case

Program Benefits Welfare cash benefits (TANF)	NC	NC		
Supplemental Security Income (SSI) cash benefits	NC	NC		
Social Security cash benefits	C	C		
Housing subsidies	NC	NC		
Foster care cash benefits	NC	NC		
Adoption assistance cash benefits	NC	NC		
Veterans benefits	C	C		
Emergency or disaster relief benefits	NC	NC		
Low income energy assistance payments	NC	NC		
Native American tribal benefits	NC	NC		
Other Types of Income (specify)				

*Make a separate column for each “other” program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select “insert” and choose “column”.

3.1.1.5 What types and *amounts* of disregards and deductions does each program use to arrive at total countable income?

Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA."

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____ Yes __**X**_ No

If yes, please report rules for applicants (initial enrollment).

Table 3.1.1.5

Type of Disregard/Deduction	Title XIX Child Poverty-related Groups	Title XXI Medicaid SCHIP Expansion	Title XXI State-designed SCHIP Program	Other SCHIP Program* _____
Earnings	**20% Gross**	**20% Gross**	$	$
Self-employment expenses	**Items necessary to produce income**	**Items necessary to produce income**	$	$
Alimony payments Received	NA	NA	$	$
Paid	NA	NA	$	$

Child support payments Received	NA	NA	$	$
Paid	NA	NA	$	$
Child care expenses	Actual	Actual	$	$
Medical care expenses	NA	NA	$	$
Gifts	NA	NA	$	$
Other types of disregards/deductions (specify)	$	$	$	$

[i] Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.1.6 For each program, do you use an asset or resource test?

Title XIX Poverty-related Groups **_X** _No ____Yes (complete column A in 3.1.1.7)

Title XXI SCHIP Expansion program **_X** _No ____Yes (complete column B in 3.1.1.7)

Title XXI State-Designed SCHIP program ____No ____Yes (complete column C in 3.1.1.7)

Other SCHIP program_____ ____No ____Yes (complete column D in 3.1.1.7)

3.1.1.7 How do you treat assets/resources?

Please indicate the countable or allowable level for the asset/resource test for each program and describe the disregard for vehicles. If not applicable, enter "NA."

Table 3.1.1.7 Treatment of Assets/Resources*****	Title XIX Child Poverty-related Groups (A)	Title XXI Medicaid SCHIP Expansion (B)	Title XX designed Progr (C
Countable or allowable level of asset/resource test			$
Treatment of vehicles: Are one or more vehicles disregarded? *Yes or No*			
What is the value of the disregard for vehicles?			$
When the value exceeds the limit, is the child ineligible("I") or is the excess applied ("A") to the threshold allowable amount for other assets? *(Enter I or A)*			

*** There is no asset/resource test**

*Make a separate column for each "other" program identified in Section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

3.1.1.8 Have any of the eligibility rules changed since September 30, 1999? ___ Yes **_X_** No

(1)Strategic Objectives(as specified in Title XXI State Plan)	(2)Performance Goals for each Strategic Objective	(3)Performance Measures and Prog methodology, numerators,
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
1.1 Market the Medicaid/Kids Connection Program	1.1.1: A. By July 1, 1998, 10 informational sessions will be delivered to targeted groups of clients, health care providers, and community partner/client advocate groups	Data Sources: Agency records Count of sessions before 7/1/1998. **3/26/98 – 6/30/98** **Measure met**
	1.1.1: B. By July 1,1999, 10 additional informational sessions will be delivered to targeted groups of clients, health care providers, and community partner/client advocate groups	Data Sources: Agency records sessions before 7/1/99. **28 sessions betwe** **between 6/30/98 and 12/31/98 not tabula** Progress Summary: **Measure met**
	1.1.1: C. By July 1, 2000, 10 additional informational sessions will be delivered to targeted groups of clients, health care providers, and community partner/client advocate groups	Data Sources: Agency records of sessions before 7/1/2000 **due July 1, 2000**
	1.1.2: A. By August 1, 1998, an ongoing distribution system for education/marketing materials will be approved by Nebraska HHS System	Data Sources: Agency records distribution system for education/marketing m **(on file)** Summary: **Measure met**
	1.1.2: B. By August 1, 1999, the above plan will be reviewed and updated based on feedback from providers and clients	Data Source: Agency records updated distribution system for education/ma **Outreach/marketing team meets weekl** **plan & develop annual outreach/market** **established for outreach.(on file)** Summary: **Measure met**.
1.2 Determine children eligible for Medicaid/Kids Connection under the new income eligibility guidelines. This is estimated to be 24,000 children.	1.2.1: By December 31, 1998, eligibility will be determined for 25% of the estimated group of 950 children who may qualify for Medicaid/Kids Connection identified for Phase I	Data Source: Agency eligibility system report enrolled children age 14 through 18 by 12/31 **enrolled children age 14-18 yr from 7/98** Progress summary: **Measure met**
	1.2.2: By July 1, 1999,eligibility will be determined for 50% of the estimated group of 950 children who may qualify for Medicaid/Kids Connection identified for Phase I	Data Source: Agency eligibility system report eligible/enrolled children age 14 through 18 b **in enrolled children aged 14-18 yr from 1** Progress summary: **Measure met**
	1.2.3: By June 30, 1999, eligibility will be determined for 12,000 additional children who qualify for Medicaid/Kids Connection, over the number eligible on April 1998	Data Source: Agency eligibility system report enrolled children (CHIP & Medicaid) under ag eligible 4/1/98 by 12,000. **Increase in enrol** **= 16,402.** Progress summary: **Measure met**
	1.2.4: By June 30, 2000, eligibility will be determined for 18,000 additional children who qualify for Medicaid/Kids Connection, over the number eligible on April 1998	Data Source: Agency eligibility system report enrolled children (CHIP & Medicaid) under ag eligible 4/98 by 18,000 Progress summary: **Measure due June 30,**
OBJECTIVES RELATED TO CHIP ENROLLMENT		

2.1 Make needed systems changes in the N-Focus Eligibility Data System	2.1.1 By September 1, 1998, systems changes related to the new income guidelines for Medicaid/Kids Connection will be functioning.	Data Sources: Agency records Methodology: Determine if systems changed **system changes implemented 9/1/98 fo** **CHIP eligible children** Progress Summary: **Measure met**
	2.1.2 On December 31, 1999 a report will be issued detailing numbers of children enrolled by county/region from the N-Focus data.	Data Sources: Actual report Methodology: Report of enrolled children by **complete (on file).** Progress: **Measure Met**
	2.1.3 On December 31, 2000 a report will be issued detailing numbers of children enrolled by county/region from the N-Focus data.	Data Sources: Actual report Methodology: Report of enrolled children by Progress: **Measure due December 31, 20**
2.2: Hire needed eligibility staff to implement this program.	2.2.1: By September 1, 1998, two additional staff will be hired in the HHSS system.	Data Sources: Agency staffing report Methodology: Review to determine that two s **(documentation on file).** Progress summary: **Measure met**
	2.2.1: By September 1, 1999, 17 eligibility staff will be hired to accommodate the increased numbers of children enrolling in Medicaid/Kids Connection	Data Sources: Agency staffing report Methodology: Review to determine that 17 lo **FTEs hired. (documentation on file).** Progress summary: **Measure met**
2.3: Train eligibility staff on the new guidelines and systems changes	2.3.1: By September 1, 1998, training will have been offered in all six HHS service delivery areas.	Data Sources: Agency records Methodology: Review of training sessions he **provided via teleconference August 199** Progress summary: **Measure met**
	2.3.2: By September 1, 1999, training will have been offered in all six HHS service delivery areas to accommodate the new staff hired to enroll the increased numbers of children..	Data Sources: Agency records Methodology: Review of training sessions he **provided to new staff.** Progress summary: **Measure met**
2.4: Offer a streamlined method of entry for Medicaid/Kids Connection applications.	2.4.1: By September 1, 1998, develop and implement a shortened single purpose eligibility form for applications for Medicaid/Kids Connection.	Data Sources: Application Form shortened application form exists. Review ag expended to print new forms. **Single-purpo** **application implemented 9/1/1998 (on fil** Progress Summary: **Measure met**
	2.4.2: By January 1, 1999 identify and develop a training plan for non-HHS eligibility sites that will accept applications for Medicaid/Kids Connection.	Data Sources: Agency records Methodology: Training plan for non-HHS eligil **implementation of presumptive eligibili** **Training conducted in September 1998.** Progress Summary: **Measure met**
	2.4.3: By April 1, 1999, 3 non-HHS eligibility sites (1 for each location) will accept applications for Medicaid/Kids Connection	Data Sources: Agency records Methodology: Review to determine number of **HHS eligibility sites (hospital providers)** **applications.** Progress summary: **Measure Met**
	2.4.4: By January 1, 2000 at least 7 additional non-HHS sites (one in each location) will accept applications for Medicaid/Kids Connection	Data Sources: Agency records Methodology: Review to determine number of Progress Summary: **Measure due January**
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
Strategic Objection #3:For those children participating in Medicaid Managed Care, provide clients with a medical home through under Managed Care. Note: Under Nebraska's Medicaid Managed Care program, clients are enrolled into the medical/surgical p broker.		

3.1: Clients mandatory for Medicaid Managed Care will be actively enrolled on a priority basis by the enrollment broker	3.1.1: By September 1, 1999, 70% of the children identified as mandatory for managed care under the Phase I Plan will be enrolled into managed care within 90 days following the date they are found eligible for Medicaid	Data Sources: Agency records Methodology: Review managed care enrollm children enrolled in managed care within 90 d **88.3% of mandatory managed care CHIP** **within 90 days of date of eligibility (1,41** **managed care/1,606 CHIP children man** Progress Summary: **Measure Met**
	3.1.2: By September 1, 2000, 70% of children identified as mandatory for managed care will be enrolled into managed care within 90 days following the date they are found eligible for Medicaid	Data Sources: Agency records Methodology: Managed care enrollment repo enrolled in managed care within 90 days of el children mandatory for managed care: Progress Summary: **Measure due Septem**
Strategic Objection #4:Increase children's access to primary care providers.		
4.1: Recruit new Medicaid health care providers	4.1.1: By December 31, 1998, develop a plan to exceed the current participation rate (83.7%) of physicians providing services to Medicaid eligible children	Data Sources: Agency records Methodology: Review agency records for pla for implementing presumptive eligibility for chi **(dated 9/1/98) for recruitment and imple** **eligibility for children (on file).** Progress Summary: **Measure met**
	4.1.2: By December 31, 1999 and by December 31, 2000, the numbers of physicians providing services to Medicaid eligible children will be increased from the previous year	Data Sources: Agency claim files Methodology: Compare # of participating pro 12/31/99, and 12/31/2000.**8/98 # of particip** **# of participating physicians = 1,689**. Progress Summary: **Measure not met for 1** **physicians increased from 3,593 to 3,89** **(public health nurse network) contracts** **homes for enrolled children.** **Measure due December 31, 2000**
	4.1.3: By December 31, 1999, and December 31, 2000, the numbers of dentists providing services to Medicaid eligible children will be increased from the previous year	Data Source: Agency claims files Methodology: Compare the number of partici # as of 12/31/99 and 12/31/2000. **# of partic** **of participating dentists 12/99 = 653.** Progress Summary: **Measure met for 12/3** **Measure due December 31, 2000**
4.2: Address barriers voiced by providers who are reluctant to become Medicaid providers or who are reluctant to take additional patients	4.2.1: By September 1, 1998, regulations authorizing HHS to offer 12-month continuous eligibility for children will be finalized	Data Sources: Agency regulations Methodology: Review regulations for policy a eligibility for children Progress Summary: **Measure met**
	4.2.2:By September 1, 1998, regulations authorizing HHS to offer presumptive eligibility to children will be finalized	Data Sources: Agency regulations Methodology: Review regulations for policy a children. **471 NAC 28-001.05 certified 7/7/9** Progress Summary: **Measure met**
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
Strategic Objection #5: Improve children's health outcomes through proxy measures of well-child visits, dental care, visual care		

5.1: Increase access of previously uninsured children to well-child care through EPSDT/HEALTH CHECK	5.1.1: By September 30, 1999, children will have equal or more well-child visits per 1000 eligible compared to the previous 12 months for the same age group (Phase I children)	Data Sources: Agency claims files Methodology: Compare well-child visits per 1 well-child visits per 1000 eligible on 9/30/98. **available to determine measure.** Progress Summary: **Measure not met. Wil** **30, 1999 when complete data set availa** **1, 2000).**
	5.1.2:By September 30, 2000, children will have equal or more well-child care visits per 1000 eligible compared to the previous 12 month for the same age group (Phase I and Phase II children)	Data Sources: Agency claims files Methodology: Compare well-child visits per 1 well-child visits per 1000 eligibles on 9/30/99 Progress Summary: **Measure due Septem**
5.2:Increase children's access to dental care	5.2.1: A. By September 30, 1999, children will have equal or more preventive dental care visits per 1000 eligible children compared to the previous 12 months for the same age group (Phase I and Phase II children)	Data Sources: MMIS dental claim files Methodology: Compare the # of preventive de children as of 9/30/99, with the # as of 9/30/9 **60/1000 (report on file).** Progress Summary: **Measure met**
	5.2.1: B: By September 30, 2000, children will have equal or more preventive dental care visits per 1000 eligible children compared to previous 12 months for the same age group (Phase I and Phase II children)	Data Sources: MMIS dental claim files Methodology: Compare the # of preventive de children as of 9/30/2000, with the # as of 9/3 Progress Summary: **Measure due Septem**
	5.2.2.A: By September 30, 1999, children will have equal or more treatment dental care visits per 1000 children compared to the previous 12 months for the same age group (Phase I and Phase II children)	Data Sources: Agency dental claim files Methodology: Compare the # of children rece per 1000 eligible children as of 9/30/99, with **69/1000. 9/1/99 = 75/1000 (report on file).** Progress Summary: **Measure met**
	5.2.2.B: By September 30, 2000, children will have equal or more treatment dental care visits per 1000 children compared to the previous 12 months for the same age group (Phase I and Phase II children)	Data Sources: Agency dental claim files Methodology: Compare the # of treatment de children as of 9/1/2000, with the # as of 8/30 Progress Summary: **Measure due Septem**
5.3: Increase children's access to visual care	5.3.1: A: By September 30, 1999, children will have equal or more visual care check ups per 1000 eligible children compared to the previous month for the same age group (Phase I children)	Data Sources: Agency visual claim files Methodology: Compare visual care check up 9/30/99, with # as of 9/30/98 by age group. **9** **(report on file)** Progress Summary :**Measure met**
	5.3.1: B: By September 30, 2000, children will have equal or more visual care check ups per 1000 eligible children compared to the previous month for the same age group (Phase I and Phase II children)	Data Sources: Agency visual claim files Methodology: Compare visual care check ups 9/30/2000, with # as of 9/30/1999, by age gr Progress Summary: **Measure due Septem**
	5.3.2: A: By September 30, 1999, children will have equal or more prescriptive lenses per 1000 eligible children compared to the previous month for the same age group (Phase I children)	Data Sources: Agency visual claim files Methodology: Compare prescriptive lenses pe 9/30/99, with # as of 9/30/98 by age group. 9 15.9/1000 (report on file) Progress Summary : **Measure met**
	5.3.2: B: By September 30, 2000, children will have equal or more prescriptive lenses per 1000 eligible children compared to the previous month for the same age group (Phase I and Phase II children)	Data Sources: Agency visual claim files Methodology: Compare # of prescriptive lens 9/30/2000, with # as of 930/99, by age group Progress Summary: **Measure due Septem**

5.4: Increase children's access to hearing screenings	5.4.1: By July 1, 2000, HHS staff will develop a plan for tracking data for the state's recommended plan for newborn hearing screening (if such a state plan is developed as of that date)	Data Sources: Agency records Methodology: Review agency records for pla hearing screening Progress Summary: **Measure due July 1, 2**
5.5: Promote better outcomes for children with asthma through promotion of comprehensive quality care	5.5.1: By July 1, 1999, the Medicaid Quality Assurance Subcommittee on Asthma in Children will identify and distribute standards of care to all Medicaid providers caring for children	Data Sources: Agency records Methodology: Identify standards of care for c if they have been distributed to all Medicaid p Progress Summary: **Measure not met. Th subcommittee will provide a plan, whic care and distribution to providers, to th December 31, 2000.**
	5.5.2: By July 1, 2000, the number of emergency room visits/1000 children with asthma compared to the previous year will decrease	Data Sources: Agency hospital claim files Methodology: Compare the # of emergency r asthma as of 7/1/2000, with the # as of 7/1/9 Progress Summary: **Measure due July 1, 2**
	5.5.3: By July 1, 2000, the number of acute inpatient hospital admissions/1000 children with asthma compared to the previous year will decrease	Data Sources: Agency hospital claim files Methodology: Compare the # of acute inpatie children with asthma as of 7/1/2000, with the Progress Summary: **Measure due July 1, 2**
	5.5.4: By July 1, 2000, the number of practitioner office visits/1000 children with asthma compared to the previous year will increase	Data Sources: Agency practitioner claim files Methodology: Compare the # of practitioner v with the # as of 7/1/1999 Progress Summary: **Measure due July 1, 2**
5.6: Promote better outcomes for children with diabetes through promotion of comprehensive quality care	5.6.1:By July 1, 1999, the Medicaid Quality Assurance Subcommittee on Diabetes will identify and distribute standards of care to all Medicaid providers caring for children	Data Sources: Agency records Methodology: Review for standards of care f distribution to all Medicaid providers. **Standa developed (on file) and distributed to pr** Progress Summary: **Measure Met**
	5.6.2: By July 1, 2000, the number of emergency room visits/1000children with diabetes compared to the previous year will decrease	Data Sources: Agency claim files Methodology: Compare the of emergency ro diabetes as of 7/1/2000 with the # as of 7/1/99 Progress Summary: **Measure due July 1, 2**
	5.6.3: By July 1, 2000, the number of acute inpatient hospital admissions/1000 children with diabetes compared to the previous year will decrease	Data Sources: Agency claim files Methodology: Compare the # of acute inpatie children as of 7/1/2000 to the # as of 7/1/99 Progress Summary: **Measure due July 1, 2**
	5.6.4: By July 1, 2000, the number of physician office visits/1000 children with diabetes compared to the previous year will increase	Data Sources: Agency claim files Methodology: Compare the # of physician of diabetes as of 7/1/2000 with the # as of 7/1/ Progress Summary: **Measure due July 1, 2**
OTHER OBJECTIVES (SPECIFY)		